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	295029	A. BUILDING _____ B. WING _____	08/21/2008

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F 000	INITIAL COMMENTS This Statement of Deficiencies was generated as a result of an annual Medicare recertification survey conducted at your facility from August 18, 2008 through August 21, 2008. The census at the time of the survey was 44. The sample size was 12. The following complaints were investigated: Complaint #NV00018338 was substantiated. See Tag F221. Complaint #NV00018514 was unsubstantiated. Complaint #NV00018748 was substantiated. No federal deficiencies were cited. Complaint #NV00018872 was substantiated. No federal deficiencies were cited. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigation, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. The following regulatory deficiencies were identified:	F 000		
F 157 SS=D	483.10(b)(11) NOTIFICATION OF CHANGES A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, it was determined that the facility failed to notify the physician that 1 of 12 residents was not getting a Potassium supplement as ordered. (#6) Findings include: Resident #6: The resident was admitted to the facility 6/16/08 following an acute care stay for a fractured femur. Additional diagnoses included Parkinson's disease, Alzheimer's disease and	F 157		

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F 157	Continued From page 2 depression. She had been cared for at home for many years by her husband. The record indicated that, on 7/24/08, a chemistry panel was drawn for Resident #6. The potassium level was reported as 2.7 and noted as a low critical result. (Normal range is 3.6 - 5.2.) Adequate potassium levels are essential for optimum kidney function and for regulating heart muscle activity. The human body is unable to store potassium and almost all potassium ingested will be excreted within the day. Facility staff notified the physician promptly of the laboratory result. A Potassium supplement was ordered twice a day for three days and then daily thereafter. A hand written note was found on the lab sheet, "Has not taken any Potassium, but about one dose. She either spits it out or knocks the glass out of our hands. What would you like to do?" The note was undated, so it was not clear when the information was relayed to the physician. Review of the Medication Administration Record (MAR) revealed that at least seven doses of the Potassium prescribed to correct the low critical potassium level were not taken by Resident #6 before the physician was notified. The Director of Nurses (DON), after looking at the record on 8/19/08, concurred that there was no documentation that nursing staff had notified the physician in a timely manner that Resident #6 did not take the Potassium as ordered.	F 157		
F 221 SS=B	483.13(a) PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to	F 221		

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F 221	Continued From page 3 treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, it was determined that the facility failed to obtain written consents for the use of physical restraints for 2 of 12 residents. (#6 and #9) Findings include: Resident #6: The resident was admitted to the facility 6/16/08 following an acute care stay for a fractured femur. Additional diagnoses included Parkinson's disease, Alzheimer's disease, and depression. She had been cared for at home for many years by her husband. It was observed during the breakfast meal on 8/19/08 that Resident #6 had a lap tray over her Geri-chair. The tray was secured in such a way that it could not be easily removed by Resident #6. Review of the record failed to reveal a consent for a lap tray with a Geri-chair. After reviewing Resident #6's record on 8/18/08, the DON agreed that, while an order for the Geri-chair lap tray had been obtained from the physician, a consent for the tray had not been obtained from the resident's responsible party, the family. Resident #9: The resident was admitted to the facility on 7/12/05. Diagnoses included obstructive hydrocephalus, cerebellar ataxia and edema. He had a history of falls. During the entry tour, at approximately 7:15 PM	F 221		

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F 221	Continued From page 4 on 8/18/08, Resident #9 was observed in a Geri-chair with a lap tray in place. The tray was secured in a way that the resident was unable to easily remove it. Review of the record on 8/19/08 disclosed that a pre-restraint/device assessment had been completed and a physician's order was obtained for the lap tray. The record failed to have evidence of consent for the lap tray. After review of the resident's record, the DON agreed that the facility had failed to obtain a consent for the lap tray.	F 221		
F 246 SS=D	483.15(e)(1) ACCOMMODATION OF NEEDS A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined that the facility failed to provide arm protection and ensure that the call light was within reach for 1 of 12 residents. (#12) Findings include: Resident #12: The resident was admitted to the facility on 12/6/07 and had had several re-admissions. The most recent re-admission date was 7/25/08. The admitting diagnoses included convulsions, nutrition deficiency, hypothyroidism, osteoarthritis, cerebral vascular accident, fractured hip, senile dementia, and	F 246		

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F 246	Continued From page 5 depression. On 8/20/08, Resident #12's medical record was reviewed. Review of the physician's orders revealed an order for Medrol, a corticosteroid, 4 mg daily. A side effect of long term steroid use is easy bruising and fragile skin. Review of the Minimum Data Set (MDS) revealed that Resident #12 needed extensive assistance, requiring one or two person physical assistance with most of her activities of daily living. On 8/20/08, during the medication pass, Resident #12 was observed talking with the medication nurse. She expressed concern regarding the bruising and discoloration on her arms. The medication nurse stated that she would wrap the resident's arms with gauze to help protect them. The resident was observed several times on 8/20/08. She did not have gauze wrapped on her arms or any other protective measure during the observations on 8/20/08. On 8/21/08, at 11:15 AM, Resident #12 was observed in her room, watching television. The resident was in a Geri-chair at the foot of her bed and positioned in front of the television set. The resident stated she was in pain, but could not reach the call light to call for assistance. The call light was observed attached to the resident's bed, approximately three feet from the resident. When stretched out, the call light was not within reach of the resident. The resident stated that she was sometimes placed there to watch television and could not reach the call light. The resident was observed without Geri-sleeves or any other protective measures for her arms during the interview.	F 246		

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F 246	Continued From page 6 On 8/21/08 at 11:20 AM, a Certified Nurses Aid was interviewed. She stated that Resident #12 had the Geri-sleeves on, but that they became soiled and were in the laundry. She stated that she did not know the resident could not reach the call light. On 8/21/08, at 1:00 PM, the Director of Nurses was interviewed. She stated that there was only one pair of Geri-sleeves for Resident #12, but that additional pairs had been ordered.	F 246		
F 248 SS=D	483.15(f)(1) ACTIVITIES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined that the facility failed to provide an ongoing program of activities designed to meet resident interests and in accordance with the comprehensive assessment for 4 of 12 residents. (#3, #4, #7, and #12) Findings include: On 8/20/08 at 10:00 AM, a group of six residents were interviewed. These six residents were not on the sample. The interview revealed the group felt there were not enough activities and that there used to be many more activities. They stated they rarely had musical programs, the ladies luncheons had not happened for quite a while, and they no longer went to the Senior	F 248		

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Center for lunch. The group expressed concern that activities were frequently cancelled without notice. The group also stated they no longer had the monthly birthday parties to celebrate birthdays and that there were no late afternoon or evening activities. They stated the activities calendars in the rooms were small and hard to read, and that usually someone came around and told them of the activities. They stated that they rarely would use the activities room to watch television or socialize as it was so far away from their rooms.

On 8/20/08, the facility's activity calendars were reviewed. The June 2008 calendar listed four activities to occur after 2:00 PM for the month. Every Saturday and Sunday at 7:30 PM, a church group was scheduled. At 3:30 PM "in room visits" was listed as an activity two days a week. The July 2008 calendar had the same church group scheduled every Saturday and Sunday at 7:30 PM. There was one activity scheduled after 2:00 PM other than room visits. The August 2008 calendar had one activity scheduled after 2:00 PM. The room visits were scheduled most days at 3:30 PM. Review of the calendars confirmed a lack of late afternoon or evening activities for the residents.

Resident #3: The resident was admitted to the facility on 2/7/07 with diagnoses including congestive heart failure, fractured femur, debility, senile dementia, constipation, anxiety, hypertension, psychosis, osteoporosis, and macular degeneration.

On 8/19/08, Resident #3's medical record was reviewed. Review of the care plan revealed that the resident did not want to attend group activities. She preferred to remain in her room,

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except for meals. An approach was documented as monitor and re-assess as needed. There were no approaches listed for one to one room visits. The activity progress notes documented one to one room visits were provided for conversation or painting her nails. Review of the resident's activity participation log for the month of June 2008 revealed no documentation of room visits on 6/7/08, 6/8/08, 6/14/08, 6/15/08, 6/17/08 - 6/22/08, 6/28/08, and 6/29/08. For the month of July 2008, there were no documented room visits for 7/5/08, 7/6/08, 7/12/08 - 7/15/08, 7/17/08-7/22/08, 7/26/08, and 7/27/08. One activity was documented as attended for the months of June and July 2008.

On 8/21/08, Resident #3's family member was interviewed. He stated that the resident used to attend church services frequently and he thought she would enjoy attending church services again.

Resident #4: The resident was admitted to the facility on 6/5/08 with diagnoses including congestive heart failure, coronary artery bypass surgery, anxiety, benign prostate hypertrophy, hypertension, depression, glaucoma, osteoarthritis, and chronic airway obstruction.

On 8/19/08, Resident #4's medical record was reviewed. Review of the Minimum Data Set (MDS) dated 6/9/08, revealed that he no time in activities. Review of the care plans revealed an approach to encourage activity and physical mobility for the resident's acute anxiety and depression. An approach for the resident's aggressive behaviors was listed as to encourage individual and small quiet group activities. Review of the activity assessment dated 8/13/08, revealed that one to one visits were to be

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provided daily. Review of the resident's activity participation log for the month of June 2008 revealed no documentation of room visits on 6/6/08, 6/7/08, 6/12/08, 6/13/08, 6/17/08 - 6/22/08, 6/28/08, and 6/29/08. For the month of July 2008 no room visits were documented for 7/5/08, 7/6/08, 7/12/08, 7/13/08, 7/16/08 - 7/22/08, 7/25/08, and 7/26/08. Nine activities were documented as attended for the months of June and July 2008.

Resident #12: The resident was admitted to the facility on 12/6/07 and had had several re-admissions. The most recent re-admission date was 7/25/08. The admitting diagnoses included convulsions, nutrition deficiency, hypothyroidism, osteoarthritis, cerebral vascular accident, fractured hip, senile dementia, and depression.

On 8/20/08, Resident #12's medical record was reviewed. The activity assessment was completed on 8/13/08 and identified that the resident needed encouragement and appeared to be withdrawn. The activity care plan identified that the resident declined all invitations to activities. One to one room visits and to encourage the resident to attend at least one activity a week were listed as approaches. Review of the resident's activity participation log for the month of July 2008 revealed no room visits or activities documented. The activity participation log for the month of August 2008 was not available.
Resident #7: The resident was admitted to the facility on 10/24/00, with diagnoses that included anxiety, diabetes type II, constipation, vascular dementia, depression, hypertension, osteoarthritis, seizures, urinary incontinence and

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hyperlipidemia.

Review of Resident #7's Physical Restraint Elimination Assessment dated 6/18/08 and Minimum Data Sets (MDS) with assessment dates of 1/20/08, 4/06/08 and 6/22/08, revealed that the resident was no longer able to make her needs known, was dependent on staff for total care, was physically limited to bed and a Geri-chair, when awake and not receiving treatments or nursing care, and spent less than 1/3 of her time involved in activities. Review of the medical records revealed that, when the resident was out of bed, she spent a majority of her time in her room, a Geri-chair was used for out of room mobility to the dining room for meals, to Catholic Mass and to music events.

Resident #7's care plan revealed she was at risk for sensory deprivation, that she was at a passive state and needed sensory stimulation. The care plan identified that activities were to provide one to one visits that included talking with the resident, sensory stimulation of touch and application of lotion to the residents hands three times a week. Activities was also to assist the resident to Catholic Mass, social programs of music and other programs to promote sensory stimulation and meet spiritual needs.

Review of the Activity Participation records for Resident #7, revealed for the month of May 2008 the resident did not receive one to one visits and was not taken to Catholic Mass or special events. Participation records for the month of June 2008, revealed the resident had seventeen one to one visits, attended one Catholic Mass, and attended one special/party event. Participation records for the month of July 2008 revealed the resident did

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F 248	Continued From page 11 not receive one to one visits, attended one Catholic Mass and attended two special events. On several occasions during the course of the survey Resident #7 was observed taken from the dining room back to her room. During the course of the survey the TV in the resident's room was frequently turned on to a Catholic station and the resident was observed to be sleeping either in her bed or Geri-chair. On the morning of 8/20/08, the Director of Nursing (DON) was interviewed. The DON confirmed that one to one visits had been limited over the past several months due to staffing in the Activities Department. On 8/21/08, the facility Administrator was interviewed. The Activities Director was not available. The Administrator stated that there had been several Activities Directors in recent months, and the current Activity Director was working on developing new programs. She stated that the residents were still able to go out, and that the Activities Director was planning to take the residents who were able to go to lunch at the Senior Center. She stated that there was a weekly shopping trip, and if the resident was unable to go, the Activities Director would shop for the resident. She stated that she thought the monthly birthday parties were taking place. She confirmed there were few late afternoon, evening, or weekend activities.	F 248		
F 281 SS=E	483.20(k)(3)(i) COMPREHENSIVE CARE PLANS The services provided or arranged by the facility must meet professional standards of quality.	F 281		

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F 281	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to transcribe physician orders to include time parameters for medication administration for 12 of 12 residents (#1 - 12) and that the facility failed to clarify orders for 2 of 12 residents. (#6 and #9) Findings include: On 8/19/08, 8/20/08, and 8/21/08, the medical records of Residents #1 - 12 were reviewed. Review of the physician orders revealed that the re-cap orders for Acetaminophen for August 2008, July 2008, and June 2008 did not include a frequency such as every 4 to 6 hours and read: 1. "Acetaminophen tablets 500 milligrams (mg) (tab 1) by mouth. Pain index scale 1 - 5 for mild to moderate musculoskeletal pain. Not to exceed 4 grams/24 hours as necessary." 2. "Acetaminophen tablets 500 mg (tabs 2) by mouth. Pain index scale 6 - 10 for moderate to severe musculoskeletal pain. Not to exceed 4 grams/24 hours as necessary." 3. "Acetaminophen tablets 325 mg (tab 1) by mouth. Pain index scale 1 - 10 for generalized fever/pain. Not to exceed 4 grams/24 hours as necessary." The monthly re-cap orders were reviewed and signed off by nursing as well as the physician. The Acetaminophen orders were transcribed the same way on the Medication Administration Records for each resident. On 8/19/08, the Director of Nurses was interviewed. She stated that there was a new	F 281		

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computer system and that there had been an error in the input information. She confirmed that there were no time frames included for the as necessary pain medication.

According to the Drug Information Handbook for Nursing, 2007 Edition, Acetaminophen dosing for adults and elderly is: "Pain or fever: Oral, rectal: 325-650 mg every 4-6 hours or 1000 mg 3-4 times/day; do not exceed 4 grams/day."

Resident #6: The resident was admitted to the facility 6/16/08 following an acute care stay for a fractured femur. Additional diagnoses included Parkinson's disease, Alzheimer's disease, and depression. She had been cared for at home for many years by her husband.

On 7/31/08, the physician ordered Rocephin 1 gram with Lidocaine. Rocephin comes as a powder and needs to be re-constituted with sterile water or Lidocaine for injection. There was no evidence of clarification of the order as to what percent of Lidocaine was to be used or the number of cubic centimeters to be administered with the Rocephin. In addition the order did not indicate when the medication was to be given, the frequency, or the route of administration.

Resident #9: The resident was admitted to the facility on 7/12/05. Diagnoses included obstructive hydrocephalus, cerebellar ataxia and edema. He had a history of falls.

On 4/28/08, a chemistry panel was drawn. The results revealed that the potassium level was 2.4, a low critical value. Normal range is 3.6 - 5.2. The physician was notified by the staff and a Potassium supplement of 40 milliequivalents

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F 281	Continued From page 14 (meq) twice a day was ordered. The resident had received 20 meq of Potassium per day prior to the lab being drawn. The resident was also receiving two diuretics which are known to decrease potassium levels. Review of the record failed to reveal evidence for a follow-up potassium level or clarification by the nursing staff with the physician. A regularly scheduled chemistry panel was to be drawn in October 2008. This was a routine laboratory order and not to recheck the low potassium level. On 8/20/08, the DON agreed that the physician should be notified about a recheck of Resident #9's potassium level.	F 281		
F 319 SS=D	483.25(f)(1) MENTAL AND PSYCHOSOCIAL FUNCTIONING Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays mental or psychosocial adjustment difficulty receives appropriate treatment and services to correct the assessed problem. This REQUIREMENT is not met as evidenced by: Based on record review, observation, and interview, it was determined the facility failed to ensure that residents displaying symptoms of depression and psychosocial adjustment difficulties were assessed and received the necessary treatment to maintain the highest level of psychosocial functioning for 2 of 12 residents. (#11 and #5) Findings include:	F 319		

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Resident #11: The 68 year old resident was admitted to the facility on 12/29/03 with diagnoses including cerebral vascular accident, dementia, incontinence, depression, congestive heart failure, hypertension, and nutritional deficiency.

The minimum data sets done on 4/14/08 and 6/30/08 indicated Resident #11 suffered from depression. The last geriatric depression scale assessment done on 6/26/08 indicated the resident was depressed and scored 10 on the depression scale.

Activity and social service notes indicated Resident #11 self-isolated and it was difficult to get the resident to participate in any activities. It was noted the resident slept most of the day.

There was no evidence in the record Resident #11 was seen by a psychiatrist, evaluated for his depressive symptoms nor was there evidence the resident had received any type of anti-depressive medication or treatment since his admission.
Resident #5: The resident was admitted to the facility on 6/16/08. Diagnoses included chronic airway obstruction, cardiac dysrhythmia, congestive heart failure, benign prostatic hyperplasia, edema, and difficulty in walking. Medications and treatments included Albuterol Inhaler, Aspirin, Avodart, Lasix, Zetia Namenda, Amaryl, K-dur, TED hose, elevation of lower extremities and Oxygen.

On the evening of 8/18/08, Resident #5 was observed propelling himself in his wheel chair in the hallway. Resident #5 had a smile on his face when this surveyor approached him. Resident #5 tried to grab this surveyor's eye glasses from my hands, stating they were his glasses. The

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Director of Nurses (DON) approached Resident #5 explaining that he had his glasses on and then distracted him with another topic. Resident #5 was observed to be easily distracted following the DON's intervention and proceeded to propel himself off down the hallway.

On 8/19/08, Resident #5's medical records were reviewed. A Minimum Data Set (MDS) re-admission assessment was completed on 7/28/08. The sections for mood and behavior patterns revealed that the resident had been experiencing persistent anger with self or others. Review of the Social Services documentation revealed a Geriatric Depression Scale assessment dated 7/24/08. The assessment for Section I advised that a score greater than five indicated probable depression. Resident #5's score was 15. The Nurses Notes on 8/11/08, 8/13/08, 8/14/08, 8/16/08 and 8/17/08 revealed that Resident #5 was resistive to care, verbally abusive, physically striking out, and had several incidents of aggressive behavior. There was a care plan dated 6/26/08, which identified "sudden and unpredictable mood and behavior changes, dementia, combative with care, verbally aggressive." The Interdisciplinary Progress Notes dated 8/4/08 revealed that Resident #5's behaviors ranged from foul language to smiling and that the behaviors were not always easily altered. The care plan and medical record did not address monitoring of behaviors and obtaining a psychology consult for probable depression.

On the afternoon of 8/19/08 the DON was interviewed. The DON stated she was aware of Resident #5's aggressive behavior and that was why she had intervened the prior evening with the encounter with this surveyor's eye glasses. The

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F 319	Continued From page 17 DON stated she was trying to prevent his behavior from escalating. The DON confirmed that behavior monitoring and obtaining a psychology consult for Resident #5 was not being done and had not been pursued. On the morning of 8/20/08, a family interview with Resident #5's significant other was completed. The significant other stated that she had known and worked with Resident #5 for over 40 years and that he had not exhibited verbal, physical or other aggressive behaviors when he had been cared for at home.	F 319		
F 325 SS=D	483.25(i)(1) NUTRITION Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation, it was determined the facility failed to ensure that 1 of 12 residents maintained adequate weight parameters. (#1) Findings include: Resident #1: The resident was admitted to the facility on 3/11/99 with diagnoses including bipolar disorder, psychosis, mental retardation, cerebral palsy, protein malnutrition, anxiety, and constipation. According to the interdisciplinary team summary	F 325		

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of 3/26/08 Resident #1 was seen by the psychiatrist in March of 2008 and increased his Depakote and Seroquel medications because of escalating behaviors of yelling out.

On 4/23/08 the interdisciplinary progress notes indicated Resident #1 exhibited tongue thrusting, difficulty swallowing, limbs drawn up to midline with hands clawed and non-functional. The physician was notified of the symptoms.

On 7/16/08 the physician acknowledged that nursing was concerned about Resident #1's facial expressions, difficulty feeding resident, and the resident's tongue sticking out. The physician noted probable extra pyramidal symptoms (EPS) from the increased Seroquel, and ordered a decrease in dose to 50 mg twice per day.

A review of Resident #1's weight record revealed the resident's weight had been stable (between 150 to 160 pounds) from January of 2007 until July of 2008. From 7/2/08 to 8/4/08, the resident experienced a 20 pound weight loss, 160 pounds to 139 pounds. There was a significant change in the resident's ability to feed himself and his ability to swallow. Observation of the resident during the noon meal of 8/19/08 revealed the resident was totally dependent on staff for eating, exhibited tongue thrusting, and could only take a small spoonful of food at a time. There also seemed a significant delay in the resident's ability to swallow.

Review of the dietician's note of 8/18/08 revealed notation of the 13.8 percent weight loss and the Resident #1 was placed on weekly weights. The only intervention noted by the dietician was to increase four ounce supplements from twice per

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F 325	Continued From page 19 day to three times per day. There was no evidence of any other aggressive interventions to decrease the resident's weight loss. On 8/19/08, the Director of Nurses was interviewed. She stated that the dietician came to the facility twice a month. She confirmed Resident #1 was noted to have swallowing difficulties and tongue thrusting in April of 2008. The DON confirmed the resident's supplements had been increased from two to three times a day, but that a swallowing evaluation had not been ordered as of 8/19/08. Cross reference Tag F 406 - Rehabilitative Services	F 325		
F 329 SS=C	483.25(l) UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329		

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F 329	Continued From page 20 This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure that all medication orders noted the clinical indication for 12 of 12 residents. (#1 - #12) Findings include: Review of the physician's monthly re-cap medication orders for Residents #1 - 12 failed to reveal evidence that the clinical indication was noted for all prescribed medications. On 8/13/08, the Director of Nurses (DON) was interviewed. The DON stated that the facility was aware of the problem with the re-cap order forms. The DON stated that the facility had a new software program and had discovered had a "glitch" in the program. Although all medications would come up on the re-cap form, the software program would only allow up to five diagnoses for five of the medications listed. The DON confirmed that the facility had not attempted to hand write in the missing diagnoses on the re-caps when needed.	F 329		
F 371 SS=B	483.35(i)(2) SANITARY CONDITIONS - FOOD PREP & SERVICE The facility must store, prepare, distribute, and serve food under sanitary conditions.	F 371		

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F 371	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observation, it was determined the facility failed to ensure food was served in a sanitary and safe manner to prevent the spread of food borne illnesses. Findings include: Observation of the tray line at the noon meal on 8/19/08 revealed the cook started the tray line after washing her hands and donning gloves. The cook then opened the plate warmer cover using the handle and turned on the warmer by pushing the start button. The cook then commenced serving food without washing her hands or changing gloves. An inspection of the dishwashing room revealed an open box of gloves stored beneath cleaning supplies. Tray line food temperatures were taken prior to the employees being served at 11:00 AM on 8/19/08. No food temperatures were taken prior to the residents being served at 12:00 PM.	F 371		
F 406 SS=D	483.45(a) SPECIALIZED REHABILITATIVE SERVICES If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language pathology, occupational therapy, and mental health rehabilitative services for mental illness and mental retardation, are required in the resident's comprehensive plan of care, the facility must provide the required services; or obtain the required services from an outside resource (in accordance with §483.75(h) of this part) from a	F 406		

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F 406	Continued From page 22 provider of specialized rehabilitative services. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to obtain a swallowing evaluation for 1 of 12 residents displaying swallowing difficulties. (#1) Findings include: Resident #1: The resident was admitted to the facility on 3/11/99 with diagnoses including bipolar disorder, psychosis, mental retardation, cerebral palsy, protein malnutrition, anxiety, and constipation. According to the interdisciplinary team summary of 3/26/08, Resident #1 was seen by the psychiatrist in March of 2008 and increased his Depakote and Seroquel medications because of escalating behaviors of yelling out. On 4/23/08, the interdisciplinary progress notes indicated that Resident #1 exhibited tongue thrusting, difficulty swallowing, limbs drawn up to midline with hands clawed and nonfunctional. The physician was notified of the symptoms. There was a significant change in the resident's ability to feed himself and his ability to swallow. Observation of Resident #1 during the noon meal of 8/19/08 revealed the resident was totally dependent on staff for eating, exhibited tongue thrusting and could only take a small spoonful of food at a time. There also seemed a significant delay in the resident's ability to swallow.	F 406		

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F 406	Continued From page 23 An interview with the DON on 8/19/08 during the meal observation, resulted in the DON requesting a speech evaluation for Resident #1. Cross Reference Tag F325 - Nutrition	F 406		
F 431 SS=B	483.60(b), (d), (e) PHARMACY SERVICES The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.	F 431		

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F 431	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, it was noted that the facility failed to ensure the safe storage of medications. Findings include: On 8/20/08, during the observation of the medication room between the 100 and 300 Halls, a urine specimen for one of the facility residents was found in a refrigerator used as a medication refrigerator. A sign was posted on the refrigerator to use for medications only. A medication cart was noted to be parked outside of the conference room on the afternoon of 8/20/08. The cart was unlocked and no licensed staff were in the immediate vicinity. It was not known how long the cart was unsecured. The hall was an area that was frequently utilized by facility residents and the medication cart was readily accessible to them.	F 431		